RECORDS /X-RAY RELEASE REQUEST FORM

Date:

Dear Dr._____ (insert name of previous dentist)

Fax, Email, or Mail this completed form to your previous dentist

I authorize the release of dental records/x-rays relevant to dental treatment for myself and/or any family member listed below to be transferred to:

Dr. Anjana Gupta
2800 Niles Road
Saint Joseph, MI 49085 Phone:
(269) 429-2511
Email: info@smilesonniles.com
Fax: (269) 429-5130

Name of patient(s):

_____

_____

_____

_____

_____

Print Name: _____

Signature: _____

Date: _____